



VIRAL HEMORRHAGIC FEVER CASE REPORT FORM

Please return to: Centers for Disease Control and Prevention, Viral Special Pathogens Branch
Ph: (470) 312-0094 Fax: (404) 471-2526 Email: spather@cdc.gov

INSTRUCTIONS

For the purposes of this form, viral hemorrhagic fever (VHF) includes diseases caused by:

- Ebolaviruses
- Marburgviruses
- Lassa virus
- Lujo virus
- Chapare virus
- Guanarito virus
- Junin virus
- Machupo virus
- Sabia virus
- Crimean-Congo hemorrhagic fever virus
- Rift Valley Fever virus
- Other emerging and high-consequence viral pathogens

Please complete this form in as much detail as possible for confirmed VHF cases.

Please record all dates as *mm/dd/yyyy*.

*Denotes a required response

VSPB EPI-NUMBER (assigned by CDC): _____

*STATE/LOCAL ID: _____

I. CASE IDENTIFICATION

*State Health Department reporting case: _____ Date form completed: _____

Person completing report: _____ Email: _____ Phone number: _____

Name of patient's physician: _____ Email: _____ Phone number: _____

Select pathogen:

- | | | | |
|------------------------------|------------------------------|---------|---------------------------------|
| Marburg | <i>Bundibugyo ebolavirus</i> | Machupo | Crimean-Congo Hemorrhagic Fever |
| <i>Zaire ebolavirus</i> | Lassa | Junin | Rift Valley Fever |
| <i>Sudan ebolavirus</i> | Lujo | Sabia | Other, specify: _____ |
| <i>Tai Forest ebolavirus</i> | Guanarito | Chapare | |

*Current case classification: Confirmed VHF case Suspect VHF case Not a VHF case

See NNDSS National Case Definition: [Viral Hemorrhagic Fever \(VHF\) 2022 Case Definition | CDC](#)

How was the case identified? Check all that apply.

- CDC Airport Public Health Risk Assessment Presented to Emergency Department/Hospital/Outpatient Clinic
Public Health Monitoring via State/Local HD Other, Specify: _____

II. CASE DEMOGRAPHIC AND CONTACT INFORMATION

Sex: Male Female	Birthdate: _____ or Age (in years): _____	Race (Check all that apply): American Indian/Alaska Native Black or African American Asian	Native Hawaiian/other Pacific Islander White Other: _____
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Ethnicity: Hispanic or Latino Non-Hispanic or Latino Unknown

Does the patient reside in the United States? Yes No

If **YES**, where is the patient's U.S. residence? State: _____ County (Provide FIPS code): _____

If **NO**, where is the patient's non-U.S. Residence?

Country: _____ District/County: _____

City: _____

Occupational Information

What kind of work does the patient do? (for example, registered nurse, janitor, flight attendant)? _____

What kind of business or industry does the patient work in? (for example, hospital, clinic, airline)? _____

III. CLINICAL HISTORY

*Date of symptom onset: _____ Unknown

Where was the patient when their symptoms first began?

Country: _____ State (if in the US): _____

District/County: _____ City: _____

Has the patient experienced new onset of any of the following?

Fever (Measured) > 38°C/100.4° Temp: C/F	Date symptom began: _____	or	Unknown
Fever (subjective) or chills	Date symptom began: _____	or	Unknown
Fatigue	Date symptom began: _____	or	Unknown
Headache	Date symptom began: _____	or	Unknown
Stomach Pain	Date symptom began: _____	or	Unknown
Joint pain	Date symptom began: _____	or	Unknown
Muscle Pain	Date symptom began: _____	or	Unknown
Diarrhea	Date symptom began: _____	or	Unknown
Conjunctivitis (red eyes)	Date symptom began: _____	or	Unknown
Rash	Date symptom began: _____	or	Unknown
Anorexia/loss of appetite	Date symptom began: _____	or	Unknown
Sore throat or pharyngitis	Date symptom began: _____	or	Unknown
Seizures	Date symptom began: _____	or	Unknown
Chest pain	Date symptom began: _____	or	Unknown
Shortness of breath	Date symptom began: _____	or	Unknown
Nausea/Vomiting	Date symptom began: _____	or	Unknown
Unexplained Bruising/Bleeding	Date symptom began: _____	or	Unknown

If YES,

Ecchymoses (bruising)	Gingival hemorrhage
Epistaxis (nose bleed)	Injection site hemorrhage
Hemoptysis (coughing blood)	Vaginal bleeding (non-menstrual)
Hematemesis (vomiting blood)	Other bleeding (<i>specify</i>): _____
Hematochezia (blood in stool)	
Hiccups	Date symptom began: _____ or Unknown
Other, please specify: _____	Date symptom began: _____ or Unknown

Is patient pregnant?

Yes
No
Unknown

If YES,**How many weeks pregnant?**

_____ weeks

Is patient breastfeeding?

Yes
No
Unknown

Has malaria testing been performed?

Yes
No
Unknown

If YES, type of Malaria test:

RDT
Smear
Other, specify: _____

Malaria test result:

Positive
Negative
Pending

If POSITIVE,**What species was detected?**

<i>P. falciparum</i>	<i>P. ovale</i>
<i>P. vivax</i>	<i>P. knowlesi</i>
<i>P. malariae</i>	Unknown

Significant results of clinical laboratory or other non-VHF testing:**Did patient die from this illness or complications of this illness?**

Yes
No
Unknown

If DECEASED:

Date of death: _____ City: _____ State: _____

Was an autopsy or other medical examination performed on the body?

Yes No Unknown If YES, Date of autopsy/medical examination: _____

What was the final disposition of the body?

Cremation, date: _____
Burial, date of funeral/burial: _____
Unknown

IV. HOSPITALIZATION(S) DURING ILLNESS

Was patient hospitalized because of this event? Yes No Unknown

Fill out table below for each facility where the patient was seen. If patient is currently hospitalized, leave discharge date blank.

Dates of hospitalization	Health facility information	How was the patient transported to the health facility	Was the patient managed under isolation precautions?	If isolated, describe (check all that apply)
Admission: _____ Discharge: _____	Health facility name: _____ City: _____ State: _____	Ambulance/EMS Personal vehicle Other, specify: _____	Yes - Date of isolation: _____ No _____ Unknown _____	Single room Contact precautions Droplet precautions Airborne precautions Other, specify: _____
Admission: _____ Discharge: _____	Health facility name: _____ City: _____ State: _____	Ambulance/EMS Personal vehicle Other, specify: _____	Yes - Date of isolation: _____ No _____ Unknown _____	Single room Contact precautions Droplet precautions Airborne precautions Other, specify: _____

Additional case details/comments:

V. TRAVEL HISTORY AND EPIDEMIOLOGICAL RISK FACTORS PRIOR TO ILLNESS

Has the patient had contact with a symptomatic VHF case (suspect or confirmed), or VHF survivor in the 3 weeks before becoming ill?

Yes, confirmed VHF case Yes, suspect VHF case Yes, VHF survivor No Unknown

If **YES**, dates of contact: _____ to _____

Nature of contact (check all that apply):

Healthcare worker wearing appropriate PPE (no direct contact with blood or body fluids)

Direct contact with blood or body fluids of a symptomatic VHF case

Contact with surfaces, linens, or other items belonging to or touched by the ill person.

Sexual contact with a symptomatic VHF case or VHF survivor

Direct contact with body of individual who died of VHF

Household or other contact (lived in close proximity without direct contact)

Other: _____

Did the patient care for someone who was sick or died in the 3 weeks before becoming ill?

Yes No Unknown

If **YES**, dates of contact: _____ to _____

Nature of contact (check all that apply):

Healthcare worker wearing appropriate PPE (no direct contact with blood or body fluids)

Direct contact with blood or body fluids

Contact with surfaces, linens, or other items belonging to or touched by the ill person.

Sexual contact with an ill person

Direct contact with body of individual who died

Household or other contact (lived in close proximity without direct contact)

Other: _____

Did the patient travel outside of the United States in the 3 weeks before becoming ill?

Yes No Unknown

If **YES**, where?

Country: _____ District/County: _____

City: _____ Dates of visit: From: _____ to: _____

Nature of travel?

Residence

Business

Visiting friends and relatives

Tourism

Medical/relief response (e.g., worked in laboratory, provided care, provided disaster relief, etc.), specify organization: _____

Other: _____

IF PATIENT DID NOT TRAVEL OUTSIDE OF THE U.S., skip to Section VI. VHF Lab Section (page 5)

Did the patient visit a healthcare facility or traditional healer (witch doctor) outside of the United States in the 3 weeks before becoming ill?

Yes No Unknown

If **YES**, fill out the table below for each facility:

Name of healthcare facility	Location	Date arrived at healthcare facility	Date departed healthcare facility	Purpose of visit
	Country: _____ District/County: _____ City: _____	_____	_____	Healthcare provider Healthcare (for self) Accompanied or visited family member or friend Other: _____
	Country: _____ District/County: _____ City: _____	_____	_____	Healthcare provider Healthcare (for self) Accompanied or visited family member or friend Other: _____
	Country: _____ District/County: _____ City: _____	_____	_____	Healthcare provider Healthcare (for self) Accompanied or visited family member or friend Other: _____

Did the patient attend a funeral outside of the United States in the 3 weeks before becoming ill?

Yes No Unknown

If **YES**, where was the funeral?

Country: _____ District/County: _____

City: _____ Dates of the funeral: _____ to _____

Did the patient participate in burial practices (touch the body, wash the body, wash clothes of the deceased)?

Yes No Unknown

Did the patient have any animal contact (including contact with body fluids of animals) outside of the United States in the 3 weeks before becoming ill?

Yes No Unknown

If **YES**, what species of animal (check all that apply)?

Bat
 Non-human primate (e.g., monkey)
 Livestock (e.g., cows, goats, sheep)
 Rodents (e.g., mice, rats)
 Other, specify:

Dates of contact:

From: _____

To: _____

Nature of contact with the animal:

Did the animal display any symptoms of illness or was the animal dead?

Yes No Unknown

Did the patient consume any meat harvested from wild animals while outside of the United States in the 3 weeks before becoming ill?

Yes
No
UnknownIf **YES**,
Date of last contact:
_____**Specify type of animal:**

Bat
 Non-human primate (e.g., monkey)
 Rodents (e.g., mice, rats)
 Other, specify:

Did the patient experience any tick or mosquito bites while outside of the United States?

Yes
No
UnknownIf **YES**, check all that apply:

Mosquito Date of last mosquito bite: _____

Tick Date of last tick bite (or tick removal): _____

Did the patient work or spend time in a mine/cave outside of the United States in the 3 weeks before becoming ill?

Yes
No
UnknownIf **YES**, location?Country:
_____District/County:
_____Date of last visit:

VI. VHF LABORATORY TESTING – *For Confirmed Cases Only*

*Where did the patient's sample test positive for VHF? (check all that apply)

- Non-CDC Laboratory
 CDC Laboratory

Non-CDC Laboratory Testing

Where was the testing performed?

Laboratory Response Network Laboratory, specify laboratory: _____

Regional Special Pathogens Treatment Center Laboratory, specify laboratory: _____

Other, specify: _____

Specimen ID from non-CDC testing facility: _____

Test Performed: Biofire Warrior Panel Other, specify: _____

*Date of specimen collection: _____ Date the test was performed: _____

Positive results (viral RNA or viral antibodies detected):

Marburg	<i>Bundibugyo ebolavirus</i>	Machupo	Crimean-Congo Hemorrhagic Fever
<i>Zaire ebolavirus</i>	Lassa	Junin	Rift Valley Fever
<i>Sudan ebolavirus</i>	Lujo	Sabia	Other, specify: _____
<i>Tai Forest ebolavirus</i>	Guanarito	Chapare	

CDC Laboratory Testing

Specimen ID: _____ *Date of specimen collection: _____ Date the test was performed: _____

Positive results (viral RNA detected)

Marburg	<i>Bundibugyo ebolavirus</i>	Machupo	Crimean-Congo Hemorrhagic Fever
<i>Zaire ebolavirus</i>	Lassa	Junin	Rift Valley Fever
<i>Sudan ebolavirus</i>	Lujo	Sabia	Other, specify: _____
<i>Tai Forest ebolavirus</i>	Guanarito	Chapare	

Specimen ID: _____ *Date of specimen collection: _____ Date the test was performed: _____

Positive results (viral antibodies detected):

Marburg	IgM	IgG	Machupo	IgM	IgG
<i>Zaire ebolavirus</i>	IgM	IgG	Junin	IgM	IgG
<i>Sudan ebolavirus</i>	IgM	IgG	Sabia	IgM	IgG
<i>Tai Forest ebolavirus</i>	IgM	IgG	Chapare	IgM	IgG
<i>Bundibugyo ebolavirus</i>	IgM	IgG	Crimean-Congo Hemorrhagic Fever	IgM	IgG
Lassa	IgM	IgG	Rift Valley Fever	IgM	IgG
Lujo	IgM	IgG	Other, specify: _____	IgM	IgG
Guanarito	IgM	IgG			

ADDITIONAL INFORMATION